REGISTRATION – *please print*

PATIENT INFORMATION

Last Name _____ First _____ Middle Initial _____

Birth Date _____/_____/_____ Age _____ Sex _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Email _____

Occupation _____ Employer/School Name _____

Marital Status _____ Guardian Names (if applicable) _____

How did you hear about us? _____

INSURANCE INFORMATION

Medical Insurance _____ Member ID _____ Group # _____

Secondary Insurance _____ Member ID _____ Group # _____

Name of Primary Holder *(Last)* _____ *(First)* _____ *(MI)* _____

Birth Date _____/_____/_____ Sex _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Patient Relationship to the Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to **Montenare Eye Care & Vision Therapy, LLC** on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above. I understand that I am responsible for any amount of my bill not covered by insurance and/or Medicare and that payment for these uncovered charges are expected on day of visit.

Signature: _____ Date _____/_____/_____

Patient Signature or Legal Representative

HIPAA PRIVACY

In the course of providing services to you, we create, receive, maintain and transmit health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The "Notice of Privacy Practices" you have been given describes these uses and disclosures in detail. **I acknowledge that I have received the "Notice of Privacy Practices" from Montenare Eye Care & Vision Therapy, LLC.**

Signature: _____ Date _____/_____/_____

Patient Signature or Legal Representative

REGISTRATION – *please print*

DEMOGRAPHICS

Race:	☐ Caucasian	☐ African-American	☐ Asian	☐ Other: _____
Ethnicity:	☐ Non-Hispanic	☐ Hispanic or Latino		☐ Other: _____
Primary Language:	☐ English	☐ Spanish		☐ Other: _____

MEDICAL HISTORY

Last eye exam? ____/____/____ Last physical? ____/____/____ Pregnant or nursing? *(For females)* □ No □ Yes

Please list any current or past **eye conditions**: ☐ None

☐ Drye eye	☐ Glaucoma	☐ Cataract surgery	☐ Other _____
☐ Cataracts	☐ Macular degeneration	☐ LASIK surgery	☐ Other _____
☐ Floaters	☐ Amblyopia ("lazy eye")	☐ Retinal surgery	
☐ Stye	☐ Strabismus ("eye turn")	☐ Strabismus surgery	
☐ Eye allergies	☐ Cornea disease / injury	☐ Retinal break or tears	

Please list any current or past **health conditions**: ☐ None

☐ Arthritis	☐ High blood pressure	☐ Hypothyroidism	☐ Other _____
☐ Asthma	☐ High cholesterol	☐ Myasthenia gravis	☐ Other _____
☐ Anemia	☐ Diabetes (Type 1 or 2)	☐ Multiple sclerosis	
☐ ADHD	☐ Migraines	☐ Autoimmune disease	
☐ Anxiety	☐ Other headaches	☐ COPD	
☐ Depression	☐ Stroke	☐ Heart surgery	
☐ Autism (ASD)	☐ Cancer	☐ Brain surgery	

Please list current **medications, vitamins, or supplements:** ☐ None

1) _____	Dosage _____	5) _____	Dosage _____
2) _____	Dosage _____	6) _____	Dosage _____
3) _____	Dosage _____	7) _____	Dosage _____
4) _____	Dosage _____	8) _____	Dosage _____

Please list any **allergies** (seasonal, medications, etc.): ☐ None

☐ Seasonal	☐ Drug allergy #1: _____	☐ Other _____
☐ Fluorescein	☐ Drug allergy #2: _____	☐ Other _____
☐ Latex	☐ Drug allergy #3: _____	

FAMILY HISTORY

Do any members of your immediate family have the following conditions?

DISEASE/CONDITION	NO	YES	RELATIONSHIP TO YOU
Glaucoma	□	□	_____
Macular Degeneration	□	□	_____
Cancer	□	□	_____
High Blood Pressure	□	□	_____
Diabetes	□	□	_____
Autoimmune disease	□	□	_____
Other _____	□	□	_____

(PLEASE CONTINUE)

REGISTRATION – *please print*

SOCIAL HISTORY

Do you drink alcohol? □ No □ Yes Type/amount/how long: _____
Do you use smoke? □ No □ Yes Type/amount/how long: _____
Do you use illegal drugs? □ No □ Yes Type/amount/how long: _____

DEVELOPMENTAL HISTORY *(For infant or elementary school)* ☐ N/A

Length of pregnancy: ☐ Full-term ☐ Other: _____ *(How many weeks?)*

Type of delivery: ☐ Natural ☐ C-Section

Were there any complications before, during, or after birth? ☐ No ☐ Yes: _____

Is your child reaching all developmental milestones? ☐ Yes ☐ No: _____

Is there currently an Individualized Education Program (IEP)? ☐ Yes ☐ No ☐ N/A

Please check if your child receives the following services: ☐ Occupational therapy (OT) ☐ Physical therapy (PT)
☐ Speech therapy (ST) ☐ Other: _____

If you are here for a **VISION THERAPY** evaluation, please check all that apply: ☐ N/A

- ☐ Blurry vision *(distance / near / both)*
- ☐ Double vision *(distance / near / both)*
- ☐ Eyes feel tired
- ☐ Eyestrain or discomfort
- ☐ Skips words or lines when reading
- ☐ Rereads the same line frequently
- ☐ Loses place while reading / use finger
- ☐ Headaches when reading
- ☐ Print "runs together"
- ☐ Words "jump" or "wiggle" on the page
- ☐ Eye turn
- ☐ Avoids near tasks (reading, computer, etc.)
- ☐ Struggles with reading/learning
- ☐ Confuse left & right
- ☐ Reverse letters, numbers, or words
- ☐ Difficulty discriminating shapes or colors
- ☐ Difficulty finding similarities/differences in things
- ☐ Easily confused with visual information
- ☐ Easily frustrated with "visually demanding" tasks
- ☐ Poor memory (especially with visuals and pictures)
- ☐ Poor spelling
- ☐ Slow at processing new visual information
- ☐ Difficulty "visualizing" a picture
- ☐ Poor eye-hand coordination
- ☐ Poor handwriting or fine-motor control
- ☐ Other: _____

If you recently had a **CONCUSSION**, please complete: ☐ N/A

Date of concussion: _____ Cause: _____

Did you require neuro-imaging (MRI, CT Scan)? ☐ No ☐ Yes – Results were: ☐ Normal ☐ Other: _____

Have you returned to school / work? ☐ No ☐ Yes (full-time) ☐ Yes (part-time)

Are you being followed by a specialist? ☐ No ☐ Yes – Name: _____

Your visual symptoms are: ☐ Improving ☐ Worsening ☐ No changes

REGISTRATION – *please print*

PUPIL DILATION

Pupil dilation is recommended for all our patients as part of their yearly eye exam. The procedure uses eye drops to enlarge the pupils, allowing the doctor to view the peripheral retina to properly assess eye health and screen for potentially vision-threatening conditions. The dilated exam aids in the detection and assessment of cataracts, glaucoma, macular degeneration, retinal tears or detachments, tumors, and other conditions affecting the eye.

A dilated exam may also reveal early signs of diabetes, vascular disease, and hypertension. Patients with a personal or family history of diabetes, high blood pressure, any known eye disease, and those having high prescriptions are strongly advised to have their eyes dilated yearly.

Important: The short-term side effects of the dilating drops include sensitivity to light, blurred vision at near, and possibly blurred vision at distance. Driving is usually not impaired. However, if you feel uncomfortable operating a vehicle under these conditions, you should reschedule dilation for another day. The effects of the drops usually last 4-6 hours. As with all medications, rare but serious side effects can occur. These may include (but are not limited to) angle-closure glaucoma (a rapid increase in eye pressure), cardiovascular issues (irregular or fast heartbeat, rapid increase in blood pressure, etc.), central nervous system issues (confusion, disorientation, etc.) or general affects (flushing of the face, dry mouth or skin, etc.).

- ☐ **I DO** want pupil dilation today and understand my vision may be impaired.
- ☐ **I WANT TO RESCHEDULE** for pupil dilation.
- ☐ **I DO NOT** want pupil dilation. In refusing this test, I release Montenare Eye Care & Vision Therapy, LLC and its doctors and staff of any liabilities that result from not having this test performed.

I have been informed by Montenare Eye Care & Vision Therapy, LLC of the need for pupil dilation. It has been explained to me and I understand that, without these tests, existing eye diseases and conditions may go undetected.

Patient Name _____

Signature _____ Date _____/_____/_____

Patient Signature or Legal Representative